435 Glenwood Road, Binghamton, NY 13905-1699
(607) 766-3828 fax 607-763-3483

Health Insurance Waiver Form
For the 2024 Plan Year.

I understand that I am eligible for health insurance through Broome-Tioga BOCES through my collective bargaining agreement, or if I am not a bargaining unit member, the District's policy on Health insurance for non-unit members. I am declining health insurance for the following reason (please place initials on line next to appropriate reason) effective ____/_____/_____:

_____Health insurance coverage through Spouse

_____Health insurance coverage through another employer

_____Health insurance coverage through a Medicare or Medicaid Supplement (Fidelis, Excellus Blue PPO, etc. through Medicaid*)

_____COBRA coverage.

_____Other. Please list reason _____

By declining coverage offered by the District, I understand my dependents and I may not be eligible to enroll for benefits until the District's next annual open enrollment period. I and/or my dependents may become eligible to enroll if there is a qualifying event, and I request enrollment within 30 days of the eligible qualifying event. I further understand that by declining coverage offered to me by the District, I may not be eligible for any subsidies if I choose to purchase health insurance on the state operated health insurance exchange.

_____	_____	_____
Employee Name - please print	Bargaining Unit	Date
_____	_____	_____
Employee Signature	Employee ID	Date

Affirmation of Alternate Coverage for receipt of cash payment in lieu of insurance.
Where the District offers any payment in lieu of health insurance coverage, the employee must have alternate health insurance coverage in order to be eligible. The employee must also be an employee for one year prior to accepting any money for declining coverage. *Medicare and/or Medicaid coverage is not considered group coverage and will not qualify for any payment in lieu of coverage for active employees. See examples above**

To be eligible for payment and have that payment processed, the employee must provide proof of coverage within 10 business days.

Acct Code:_____ FTE% _____ = $_____
Acct Code:_____ FTE% _____ = $_____
Acct Code:_____ FTE% _____ = $_____

Department Head:_____ Date___/___/____
Given to Payroll: ____/____/_____